

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041491

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10304

STATE FILE NUMBER

FILED OCT 31 1963

VS 300
Rev. 4/59

1

2

3

4

5

6

7

8

9

10

11

12

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK
OR
TYPEWRITER RIBBON

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN St. Louis

Length of stay in 7b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION Bethesda General

Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis

c. CITY OR TOWN Rock Hill

Inside Limits
Yes ☒ No ☐

d. STREET ADDRESS 115 N. Rock Hill Rd.

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED

First

Middle

Last

(Type or print)

Emma

S.

Gould

4. DATE OF DEATH

Month Oct.

Day 15

Year 1963

5. SEX F.

6. COLOR OR RACE W.

7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH 7/29/87

9. AGE (last birthday) 76

IF UNDER 1 YEAR
Months Days

IF UNDER 24 HR
Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife

10b. KIND OF BUSINESS OR INDUSTRY
At Home

11. BIRTHPLACE (City and state or country)
Blackoak, Illinois

12. CITIZEN OF WHAT COUNTRY
USA.

13a. FATHER'S NAME

Graham

13b. MOTHER'S MAIDEN NAME

Crowley

14. NAME OF HUSBAND OR WIFE

none

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Margerie M. Wood, 9119 Wrenwood La.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Lobar pneumonia (left)

INTERVAL BETWEEN ONSET AND DEATH
40 hrs

DUE TO (b)

Fracture of the rt. hip

3 days

DUE TO (c)

Arteriosclerosis general.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

Fell at home

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year
10-10-63

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
home

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

Rock Hill, Missouri

21. I attended the deceased from Oct 10 1963 to Oct 15 1963 and last saw her alive on Oct 15 1963
Death occurred at 3 22 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

23e. STATE

24. FUNERAL DIRECTOR

ADDRESS

25. DATE REC'D. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Parker-Aldrich, Webster Groves, Mo.

OCT 16 1963

Robert Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Leslie Welch

Licensed Embalmer No.

4395

P. O. Address

Webster Groves Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.